Enuresis

A Critical Review of the Symptom

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• Enuresis is a symptom for which many kinds of treatments ranging the gamut of unscientific medical practices have been tried. To establish bladder control at the appropriate age is important because it means self-control, one of the foundations of a healthy personality. In most children with enuresis there has been no convincing demonstration of organic pathology of the urinary system. The cure of enuresis lies in the correction of psychological causal factors such as sibling jealousy, suppressed hostile feelings and sex difficulties. Routine urologic investigation of enuresis is unwarranted and unkind, unless there is a valid medical indication. Any therapeutic program for enuresis should center upon the child and not his bladder.

THERE ARE FEW PROBLEMS in pediatric practice, or in psychiatric practice for that matter, that are more troublesome to physician, parent and patient than enuresis. Enuresis is usually defined as the involuntary passage of urine by persons more than three years old. This does not mean that a child is called enuretic at the age of three and a day; the outer limits are more elastic. The problem is one that seems to impel parents and physician to "do something," and yet the physician ought not be stampeded into doing "something, anything to get rid of this."

Data from the Johns Hopkins Clinic indicated that some 26 per cent of the complaints at the psychiatric service of the clinic were concerned with bedwetting, and that in 78 per cent of the cases of enuresis, the condition was life long. Fifty per cent of patients with enuresis wet the bed daily. The peak incidence of the complaint was between 8 and 11 years, which probably means that persistence of enuresis to that age led parents to seek help rather than that it is truly more frequent in that period. At Bellevue Hospital, one-fourth of enuretic patients were over seven years of age.

Bedwetting is an annoying symptom, but what if it is simply ignored? In the great majority of cases it ceases in puberty. Why not, then, just let it go instead of going through strenuous procedures? Why, in taking routine psychiatric histories of adults, is inquiry made about the presence or absence of enuresis in childhood? Why do psychiatrists stress the importance of enuresis as a clue to later personality problems?

The way children control their bodies establishes the pattern of their general self-control. A child unable to control his body, usually is unable to control feelings. He cannot wait; every whim has to be fulfilled immediately. He becomes furious and helpless when crossed, bursting out in temper tantrums which overwhelm him in the way, as one writer put it, "the stream of urine overwhelms the body."

To establish bladder control is important because it means self-control; to establish self-control is one of the foundations of education—to enable the child to be consistent and insistent in his efforts to reach certain goals, even if getting there takes labor, time and patience. Some of the bedwetting children steal, one of the reasons being that they must have what they want immediately; they cannot ask their parents' permission, or wait until the next holiday comes around when presents are in order.

When they get into school many are often poor students, however intelligent they may be, because they cannot apply themselves, cannot concentrate, cannot follow orders. They are unable to control their impatience in learning, as they are unable to wait until they get to the bathroom at night. They want to succeed immediately or they give up. Some of these children frequently get into trouble sexually because in this matter, too, they lack control and have to follow every urge immediately. The establishment of bladder control becomes one of the crossroads of education and character foundation.

The foregoing does not hold true of all enuretic children. Some children are difficult to manage, others are completely ruled and dominated by their mothers, are timid and lacking of initiative. The conviction of a child that he is unable to control his body gives him a feeling of being unable to achieve anything and he feels discouraged in trying anything new. Frequently the timid sort of bedwetter is conspicuous by his dirty, neglected appearance, and his whining crybaby attitudes. He gets beaten up by

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other children and does not know how to defend himself. It is interesting to see how the appearance of such a child improves when he is able to master his bladder even for one night. (No wonder physicians and parents are easily led to "try anything.")

The effects of bedwetting on the general well-being and on character formation are such that it is vastly important to help the child overcome this difficulty, to take responsibility for his own micturition. Yet even this great importance is not reason enough to "try anything" to stamp out the symptom.

In the vast majority of children with enuresis there has been no convincing demonstration of organic disease of the urinary system as the cause. Incidentally, children with bladder and urethral injuries have been helped to achieve bladder control as long as the bladder sphincter was intact. Studies have been done to determine the role of the specific gravity of the urine, and in many children the specific gravity is lower during the night. The fact that many enuretic children are highly sensitive to cold, damp weather or excitement does not establish a causal relation. Some studies have shown a relatively large proportion of enuretic children have abnormal electroencephalograms. But coincidence does not always spell causal relationship.

Spina bifida, local irritation, phimosis, balanitis, urethrotrigonitis, congenital urethral obstructions of varying degrees, and adenoids have been considered causal to some degree or other but, except for a case here or there, the evidence is unconvincing. The author has observed cases in which boys of six or seven years of age, who had achieved sphincter control at an early age, became enuretic after circumcision. Circumcision is no cure for enuresis and there is really never any valid reason to recommend it for enuresis. Depth of sleep has been blamed but many bedwetters are light, restless sleepers. Incidentally, electroencephalographic studies of the sleep habits of bedwetters show that their sleep level is lightest at the moment of micturition. Epilepsy and hysteria have been blamed and it is possible that enuresis may be one symptom in the complex of symptoms composing epilepsy or hysteria. Inherent inferiority of the urinary system, and enuresis as a symptom of choice to realize a variety of goals, has been proposed as an explanation. But what is "inherent inferiority of the urinary system," and what are tenable criteria of "inferiority"? They do not bear objective scrutiny.

The foregoing may occasionally play a role in a case here or there but are not important as causal factors. The influence of training and parental attitudes is a much more frequent important factor. Maternal over-protection, maintenance of the infantile state of the child long after it is appropriate, *is* an important factor. An extreme example is the case of a seven-year-old girl who was adoringly carried about in the arms of her parents on every possible occasion. She never had to do anything she did not want to. Enuresis and infantile speech were among many symptoms of general immaturity.

A syndrome has been described suggesting that the condition is the result of a developmental abnormality characterized by the familial nature of the condition, a "sensitive bladder" throughout life, and a sense of urgency. It is more likely that this syndrome fosters the folklore notion of a "weak bladder" or "weak kidney," and that it is "hereditary" is more likely the persistence of the family tradition of enuresis.

Lack of opportunity for adequate training is an accessory factor in rural homes or in crowded urban areas where toilet facilities are outdoors or in the basement. Inconvenience of opportunity to void leads to the use of the bed for that purpose. At a recruits camp while in the naval service, the author had occasion to see many enuretic men from backgrounds where there was lack of opportunity for toilet training and a family tradition of enuresis. Enuresis often ceased with marriage and its demands.

Psychiatrists, by and large, are not inclined to regard enuresis as a "bad" habit but rather as a complex symptom in most instances. The psychogenesis of enuresis is well recognized by them, and the importance of various emotional difficulties in the production of this symptom has been rather well studied. Rarely is it the only symptom in the patient and there are usually behavior problems and unhealthy personality features associated with it. The behavior problems include eating problems, temper tantrums and stealing. Unhealthy personality features range from whining irritability to aggressive behavior to timidity and seclusiveness.

Enuresis after an illness or an operation or during separation for any reason from the parents, or upon arrival of a new baby in the family, is well known. Nagging, punitive attitudes of a parent, fear of harm from persons of the opposite sex, sexual fantasies and repressed aggressive impulses are other dynamic factors. The dynamic factors operating in a particular case can be determined only by a careful history and a psychological evaluation of the child.

While most children are dry at night by the age of three years, the tendency today is to allow for individual differences and not label a child enuretic until after the age of four years if a girl and five years if a boy. Bedwetting persisting beyond these age limits requires careful evaluation and investigation. No intelligent child likes to be a bedwetter or to endure the psychological consequences.

Parents certainly do not like the bother of a wet child and damp bed. They react with annoyance,

irritation, impatience, anger more often than not—and it *is* hard to maintain an attitude of either calm ignoring or calm disappointment if the wetting continues day after day. Yet parents' attitudes are very important because the secondary symptoms produced in the child by punishment, scolding or other measures—symptoms like embarrassment, lack of self-confidence, feelings of guilt and inadequacy, feeling different or physically tainted, sensitiveness, unhappiness, feeling defeated—may be present in varying degrees and may be as difficult to deal with as the primary symptom.

It *is* a messy business and when pressures at home are great enough, they are usually dumped into the lap of the pediatrician to "do something." Parents are ingenious in their efforts to "do something." What they do depends upon their temperament. Interestingly, they resort largely to punitive measures. Making a child wash fouled linen, rubbing soiled linen in the child's face, making a boy wear girls' clothes, threats of operations or of doctors doing dire things, forcing the wearing of diapers, name calling—these are some of the "corrective" methods attempted.

The medical profession has often forgotten that the child and not his bladder stands in the center of any therapeutic program for enuresis. Also, in the vigorous attack upon the symptom, the medical profession was violating one of its basic teachings—that one attacks the causes and not the symptom alone. And, simply stated, since the majority of enuresis cases originate in psychologic problems, the attack might be directed toward the resolution of these problems—and by psychological methods.

In the 1930's the mechanical and surgical procedures devised were many—tying of the prepuce at bedtime, closure of the orifice with collodium at night, clamping the penis, presacral neurectomy, circumcision and tonsillectomy, to mention a few. One still sees circumcision recommended as a cure for enuresis.

Various drugs and endocrine preparations have been used and are still being used—urotropine, calcium salts, quinine, camphor, trasentin, benzedrine, desiccated thyroid, pituitary extract and testosterone. Belladonna is still a widely recommended drug and its physiologic action well known to physicians. Testosterone is still widely used to improve bladder muscle tonus. Benzedrine is used to allay the overactivity or overanxiety of the child. Note that with most measures the attack is on the bladder.

Dubious methods, euphemistically labeled psychological, like rudeness, scolding, hypnotism or giving bitter-tasting medicines were also tried. Dietary restrictions play a role too. Limitation of fluids and ample salt late in the day were popular and are used today. Some physicians recommend 5 gm. of salt or a very salty sandwich before retiring in order to bind fluid, so that less will be in the bladder.

Despite occasional success, children continued to wet. When there is such a diversity of therapeutic measures, surely there must be suspicion that we have not arrived at an appropriate therapeutic measure. And when successes come from such a diversity of methods, perhaps the methods are not so important. Perhaps, in the last analysis, the procedure meant something to the participating children in the direction of alleviating anxieties, hopelessness, and guilt about a "bad" habit—plus freedom from parental pressures and relief in a doctor's taking over the responsibility. Perhaps the interest the physician showed in the children was a paramount factor.

One may speculate as to why the vigorousness of the attack on enuresis, particularly as to the punitive, cruel measures so commonly employed. The same attitude is noticed in dealing with thumbsucking, soiling and masturbation problems. Perhaps such symptoms arouse anxiety disturbances in the adults dealing with them, who then react in a harsh punitive way to suppress these disturbances by suppressing the stimulators. Enuresis is labeled a "bad" habit, with the emphasis on "bad," and we do tend to punish "bad" things.

Certainly, if there is any medical indication, urologic procedures are necessary. But routine use of urological procedures is not warranted. To hear that "vigorous cystoscopy" or "urethral dilatation" will cure the "habit" is a little disheartening, for they are no more than the barbaric practices of the past dressed up in the guise of modern medicine. True, enuresis may stop after such a procedure is carried out; but enuresis is a symptom, often a complex one, and suppression of symptoms is not the goal of scientific medical practice. Nor is suppression of a symptom ever to be confused with the eradication of a condition producing it.

Today, a great deal is heard about various "conditioning" apparatuses and the great successes achieved with them. It is true that in many instances the symptom, enuresis, ceases. It is true that children, defeated and hopeless with their bedwetting, are buoyed up by their success. But it is also true that "conditioning" of this kind is primarily a symptom remover, and that, as with the more primitive measures used, factors more important in the success than the method may be the interest shown in the child, the wanting to help him, to remove him from his shameful status, to relieve his anxieties, guilt and hopelessness. A question not satisfactorily answered is: What happens when a symptom is suppressed by these methods? Long-range careful studies of children exposed to the conditioning apparatus are necessary, for it is probable that unless the psychological climate in which the unhealthy symptoms

are produced is resolved, suppression of a symptom merely produces another in some other area or system. The author has observed a number of children in whom conditioning was not successful, and also successfully conditioned children with new symptoms.

A recent study at University of California, Los Angeles, the subject of a doctoral thesis by M. Kahane, testing the efficacy of conditioning as a treatment for nocturnal enuresis was most illuminating. Although all patients in the experimental group using the conditioning apparatus responded successfully for at least one month after treatment, symptom remission was transitory. Thirteen of the 21 patients had relapse at intervals of one to seven months following treatment. Of the 22 untreated enuretic children in the control group, ten had spontaneous remission of symptoms within a month following contact with the examiner. In this group remission occurred more often in older children. In both experimental and control groups, behavioral change followed symptom remission. In the conditioning group, improved adjustment did not necessarily follow symptom remission. In the control group, however, all patients who had spontaneous remission of symptoms also manifested improved adjustment. In studies made by others of the use of conditioning apparatus, success was reported in a high proportion of cases, but controls were lacking.

Accessory measures, like limitations of fluids, waking the child, keeping a chart and rewarding the child for dryness have their value in certain instances but they are only accessory. Drugs and manipulations ought to be avoided. As Kanner stated, the aim is "strengthening the child's self-reliance in an atmosphere of freedom from punitive and otherwise hostile practices, from pseudomedical notions, and from anxieties superimposed on the enuresis."

The therapeutic approach to the problem of enuresis, granted no organic disease—fortunately rare—is as follows:

1. Removal of punishment and disparagement by all persons dealing with the child, especially the parents. Cruel, punitive attitudes on the part of parents must vigorously be discouraged, and the nature of enuresis explained.

2. Manipulations and drugs are to be avoided.

3. The physician should help the child to view enuresis as a symptom not as "badness," relieving his guilt. The physician becomes the child's ally, and guides the parents. (Cessation of drugs and of manipulations provides the child the safest guarantee that he is not physically ill.)

In Kanner's experience, the pediatrician helping parents with their attitudes, and both helping and encouraging the child who is considered an individual and not merely as a bladder, is likely to be successful. The author's experience and inclination has been to encourage pediatricians to deal with enuresis in most cases, and not automatically refer the patient to a psychiatric clinic or to a psychiatrist, although they may need psychiatric counsel to guide them or tide them over. Of course, there are very complex cases in which referral to a psychiatrist is indicated.

If the pediatrician tries to understand the child and his needs and deals with him as an individual, then treatment becomes facile and rational.

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